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Barriers to Effective Implementation of Programs for the Prevention of Workplace Violence in Hospitals

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Abstract

Effective workplace violence (WPV) prevention programs are essential, yet challenging to implement in healthcare. The aim of this study was to identify major barriers to implementation of effective violence prevention programs. After reviewing the related literature, the authors describe their research methods and analysis and report the following seven themes as major barriers to effective implementation of workplace violence programs: a lack of action despite reporting; varying perceptions of violence; bullying; profit-driven management models; lack of management accountability; a focus on customer service; and weak social service and law enforcement approaches to mentally ill patients. The authors discuss their findings in light of previous studies and experiences and offer suggestions for decreasing WPV in healthcare settings. They conclude that although many of these challenges to effective implementation of workplace violence programs are both within the program itself and relate to broader industry and societal issues, creative innovations can address these issues and improve WPV prevention programs.

Keywords

Workplace violence; workplace violence prevention; violence perception; program barriers; program effectiveness; reporting; bullying; customer service; accountability; profit-driven management; mentally ill

Healthcare workers are nearly four times more likely to be injured and require time away from work as a result of workplace violence (WPV) than all workers in the private sector combined (Bureau of Labor Statistics [BLS], 2013). Seven states have enacted laws to reduce WPV against healthcare workers by requiring workplace violence prevention programs (American Nurses Association, 2014). WPV programs are needed in all healthcare settings. Although inpatient hospital settings have received significant attention regarding WPV programs, other settings, such as home health, developmental centers, and hospice care are reported to have significant deficiencies regarding WPV prevention programs (Gross, Peek-Asa, & Nocera, 2013; Nakaishi, Moss, & Weinstein, 2013; West, Galloway, & Niemeier, 2014).

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The New Jersey Department of Health and Senior Services (NJDHSS) regulations for covered healthcare facilities (inpatient acute care, inpatient behavioral health, nursing homes, and specialty hospitals) require the formation of a workplace violence prevention committee, the utilization of reporting systems to track violent incidents, annual security reviews of the hospital environment, specific training requirements for all staff, and a comprehensive policy and WPV prevention plan (NJDHSS, 2012). Similarly, the Occupational Safety and Health Administration (OSHA) has identified several key elements of an effective WPV prevention program. These elements include management commitment and employee involvement; worksite analysis; hazard prevention and control; safety and health training; and recordkeeping and program evaluation (OSHA, 2004).

McPhaul, London, and Lipscomb (2013) and Lipscomb and El Ghaziri (2013) have further evaluated and assessed comprehensive WPV programs in healthcare. These authors have advanced the idea that the worksite analysis should include an assessment of barriers to removal of hazards rather than just an inventory of WPV hazards (McPhaul et al., 2013).

The aim of this study was to identify the major barriers to implementation of effective workplace violence prevention programs in hospitals. As a first step in better understanding barriers to implementation of effective workplace violence prevention programs, we conducted a study utilizing focus groups of nurses and allied health professionals. We obtained baseline information about their perceptions of barriers to effective implementation of WPV prevention programs within hospitals. In this article, we will review the related literature, describe our research methods and analysis, report the seven themes participants shared as barriers to effective implementation of workplace violence programs, and discuss our findings in light of previous studies and experiences. Although many of these challenges to effective implementation of workplace violence programs are both within the program itself and relate to broader industry and societal issues, creative innovations can begin to address these issues and improve WPV prevention programs.

Review of the Literature

It has been documented in the literature that nurses and allied health professionals are at an increased risk of workplace violence compared to other professionals. However, there are gaps in the literature regarding the effectiveness of programs in addressing this risk. This section will summarize research that has been conducted to date in four areas, specifically barriers to reporting of WPV events, the impact of training, the impact of policies, and management involvement.

Barriers to Reporting of WPV Events

Underreporting of workplace violence is a well known barrier to effective implementation of WPV programs because the lack of reporting does not permit easy identification of trends and problem areas within the hospital (Gallant-Roman, 2008). There are many reasons for underreporting, including the feeling that violence is ‘just part of the job;’ that nothing will be done about the problem reported; and that the person in the position of power to whom the report would be sent is the perpetrator (Gallant-Roman, 2008). One study found that only 57% of physical violence and 40% of non-physical violence is reported, and that of

these reports approximately 86% are simply verbal reports to supervisors (Findorff, McGovern, Wall, & Gerberich, 2005). As a result, formal reporting through mechanisms utilizing incident forms were rare in areas without regulations. However, formal reports are now mandated in many of the state laws for violence prevention in healthcare (NJDHSS, 2012).

Findorff et al. (2005) found a much higher likelihood that the employee would report the incident in situations:

- where the nurse told the perpetrator to stop but the perpetrator would not listen;
- that resulted in lost work time following the violent incident;
- when there was an increased frequency in verbal and non-physical threats of violence;
- that involved incidents with more adverse health symptoms resulting from violence;
- where the employee used the employee assistance program (EAP) services after an incident; and
- where the employee used the healthcare system to treat the physical and mental wounds of violence.

This study by Findorff and colleagues demonstrated escalation, injury, and repetition of events to be key factors that increased motivation to report WPV incidents among healthcare workers.

Impact of Training

Although several studies have investigated the impact of training healthcare providers for violence prevention, these studies have had mixed results and significant limitations (Anderson, 2006; Livingston, Verdun-Jones, Brink, Lussier, & Nicholls, 2010). One study reported that the majority of recently graduated nurses (83%) believed that education about violence prevention and bullying should be included in their nursing education curriculum; yet only a small percentage of recently graduated nurses (22%) actually received any such training during their academic preparation (Vogelpohl, 2011). Several studies have found that both knowledge of how to report work place violence and the use of personal cell phones increased the reporting of WPV incidents (Gerberich et al., 2005; Nachreiner, et al. 2005). A study by Allen (2013) found that an educational program among acute-care psychiatric nurses was effective in decreasing the number of assaults. The regulations enacted in New Jersey attempt to remedy training-related barriers to effective programs by requiring annual training of employees (NJDHSS, 2012).

Impact of Policies

Research in other industries, such as educational institutions, has shown that comprehensive policies can be effective at reducing physical violence (Feda, Gerberich, Ryan, Nachreiner, & McGovern, 2010). In contrast, a study of a substance abuse facility found that the policies and programs in place did not change the employees' perception of their risk of violence or

their ability to respond to violence. However, these employees may not have been familiar with the scope of the prevention program (Adamson, Vincent, & Cundiff, 2009).

Management Involvement

Another barrier is bullying, which has been well described in the literature, especially among new nurse graduates and nursing students (Berry, Gillespie, Gates, & Schafer, 2012; Thomas & Burk, 2009). Vogelphol (2011) has reported that surveys of nurses have found that the most likely perpetrators of bullying are fellow nurses and physicians. However, these same surveys have also reported a perception among nurses that bullying by supervisors, management, and administrators is also significant. Mitigating factors for bullying include enhancements to the workplace violence prevention program that facilitate structural empowerment of nurses (Laschinger, Grau, Finegan, & Wilk, 2010); utilization of a management structure that allows employees to have some control over the work environment and resources (Rodwell & Demir, 2012); and reduction of negative emotions among the workers (Rodwell & Demir, 2012). The New Jersey regulation attempts to facilitate structural empowerment by requiring that half of the workplace violence prevention committee consist of staff employees involved in clinical care (NJDHSS, 2012).

Research Methods and Analysis

Our qualitative study utilized two focus groups to characterize perceptions and opinions of unionized nurses and allied health professionals regarding barriers to effective implementation of WPV prevention programs in hospitals. The study was approved by the Institutional Review Boards (IRB) of Old Dominion University, University of North Carolina – Chapel Hill, and by the National Institute for Occupational Safety and Health. The participants were identified through a local New Jersey Union, the Health Professionals and Allied Employees (HPAE) union. Union shop stewards at New Jersey hospitals were notified via E-mail about the focus groups and invited to participate at one of the union's scheduled standing meetings held in May of 2012. Participants were eligible if they were a member of the HPAE union, were the representative of the union at their hospital or employer, were an employee and not considered management, and were familiar with the NJ Violence Prevention in Healthcare Facilities Act regulations (NJDHSS, 2012). Twenty-seven of the 30 union shop stewards met the inclusion criteria, consented, and participated in a focus group discussion. The focus group discussions were anonymous in the sense that participants' names were not recorded and participants were instructed to avoid using colleagues' names and names of employers. Therefore, documentation of consent was waived by the IRB and verbal consent procedures were used.

Focus group facilitators read an approved, informed consent narrative prior to the start of each focus group session; they asked each participant to verbally acknowledge their consent to participate. The New Jersey Violence Prevention in Healthcare Facilities Act regulations (NJDHSS, 2012) were in effect at the time of this meeting and as such required covered healthcare facilities to form a workplace violence prevention committee, to utilize reporting systems to track violent incidents, to conduct annual security reviews of the hospital environment, to provide specific training requirements for all staff, and to have a comprehensive policy and WPV prevention plan. Each participant was from a different

hospital or healthcare organization; hence the experiences at 27 different organizations were represented. The 27 attendees of this meeting were divided into two, roughly equal-sized groups. The first author (JB), a trained facilitator, served as the group facilitator for the first group. The second and third authors (MR and DH), who were also trained facilitators, served as facilitators for the second group. Each focus group lasted approximately two hours, for a total of four hours of discussion. No incentives were provided to the participants of the focus group sessions for their participation.

The focus group facilitators utilized the same prompt sheet for each group to guide the discussion. This prompt sheet was developed and reviewed both by the researchers conducting this study and by union representatives prior to use. The primary inputs used to develop the prompt sheet were prior studies that involved employee interviews about perceptions of violence (Blando et al., 2013) and interviews that we were currently conducting for a different study with hospital security directors regarding NJ regulations. The goals of the prompt sheet were to facilitate discussion among three major areas of interest, in the following order: a general discussion about workplace violence and the barriers to effective prevention programs; a discussion of legislative actions that attempt to prevent violence in healthcare settings; and finally a sharing of participants' perceptions of what constitutes violence in healthcare. Focus group facilitators allowed participants to express opinions that diverged from these three major areas if they were related to workplace violence; they only intervened when the length of time utilized by the participant was excessive. This was designed to allow the researchers to capture important thoughts and opinions related to workplace violence in general terms.

Transcripts were generated from the digitally recorded sessions and participants agreed to the recording both in the verbal informed consent procedures and with an additional confidential signed document collected by NIOSH attesting to release of their rights to the audio recording. Handwritten notes were not taken by any of the focus group facilitators during the focus group sessions.

Following these sessions, the digital audio recordings were converted into written transcripts and then coded by project staff. NVivo v10 (QSR International, 2014), a qualitative research software tool, was used to manage the coded themes that emerged from the collected interview data. Any theme referenced by more than three participants was flagged for manual inspection and assessment. The transcript segments that corresponded to a flagged theme were then manually inspected by project staff. The research team categorized the identified flagged themes, which are discussed below.

Findings

There were a total of 27 focus group participants, 13 in one focus group and 14 in the other group. Almost all focus group participants worked in a hospital setting and had direct patient contact (See Table 1).

Nearly half of the participants worked day shift and the other half worked the evening or night shift. Approximately 22%, six of the 27 participants, were male. The predominance of female workers in nursing is well established, as the United States (U.S.) Census Bureau in

2011 found that 91% of nurses were women (U.S. Census Bureau, 2013). The participants also represented experienced workers, as all participants had practiced in their respective fields for at least several years. These participants were active in their New Jersey union and were very familiar with legislative and management-labor-relation issues.

The participants identified seven primary themes indicating major barriers to effective implementation of workplace violence prevention programs in hospital settings (See Table 2). Focus group participants felt that each of these barriers presented significant impediments to effective workplace violence prevention programs. Table 3 lists specific quotes from participants that illustrate the individual themes identified in this analysis.

Discussion and Implications

Previous studies have addressed WPV and offered recommendations for action. This study is unique in that it presents WPV concerns in the words of those directly involved in seeing and/or reporting WPV situations. We will now discuss, in the above-listed order, the seven themes (barriers) our focus group participants have helped us to identify and then suggest strategies to overcome these barriers to WPV prevention.

Reporting is an important measure for addressing workplace violence; it allows the WPV prevention program to identify trends and problem areas within the hospital and to develop appropriate interventions to prevent WPV. However, the focus group participants overwhelmingly agreed that many healthcare providers believe that reporting is a waste of time because effective corrective actions do not result from their reports. It is important that WPV prevention programs address and acknowledge reports received from employees, so employees know that the sharing of their concerns is valued and that management has an interest in correcting the reported concern. It has been well established in the occupational health community that when employees feel that there is a real benefit to a safe action, they are more likely to engage in that safety-oriented action; when they believe there is no real benefit, they are much less likely to engage the safety system (Arezes & Miguel, 2006; Village & Ostry, 2010). The ‘Hawthorne Effect’ relates to the finding that employee productivity and engagement increase when management demonstrates a sincere interest in their employees and in employee behaviors (Landsberger, 1958). These effects are particularly relevant for healthcare workers because of the pace and intensity of their work activities. If employees do not feel valued, or identify benefits to reporting, they will likely not report incidents of violence in the workplace.

Violence is very contextual, and perception of violence has a dramatic impact on the employees’ motivation to report. It has been established that perceptions of violence vary significantly across different disciplines (Blando, O’Hagan, Casteel, Nocera, & Peek-Asa, 2012). For example, psychiatric nurses are likely to view a violent act as non-violent by attributing the act to the patient’s disease condition. Blando and colleagues (2012) have suggested that staff development sessions be tailored to the healthcare specialty receiving the training. Focus group participants particularly emphasized that many nurses view the intent of the perpetrator as being key to whether they consider an act violent and also that

personal circumstances and family situations factor into their decision regarding their reaction to violence (See Table 3).

It has been recognized that bullying in all forms, both superior to subordinate (vertical) and nurse to nurse (horizontal), has a high prevalence in the nursing profession (Berry et al., 2012; Thomas & Burk, 2009). The negative impact of bullying has also been demonstrated in relation to employee retention and productivity (Berry et al., 2012). All employees have the potential to bully; however, St-Pierre and Holmes (2008) found that increasing influence and reducing accountability increases the risk of bullying. This can occur whenever the perpetrator has more power, such as a supervisor, and workplace culture dictates few repercussions for 'bad' behavior. Frequently, nurses experiencing horizontal violence find that group dynamics are utilized to increase influence, such as when a group of nurses "gang up" on one nurse who is an "outsider." Members of the group can exert more influence because they are acting together and can also reduce the risk of consequences by defending one another should the situation become public knowledge. As a result, there must be a reporting system that holds all individuals, at any level in the structure of an organization, accountable. Unfortunately, many focus group participants felt that their WPV prevention programs did not effectively address bullying at their healthcare facility. These participants believed that people were not being held accountable and were allowed to continue to bully; employees that complained were labeled as trouble makers; hazing of new nurses was still considered acceptable; and many different and subtle ways of bullying were continuing in spite of organizational directives to the contrary (See Table 3).

The influence of financial concerns and profit-driven-management models also significantly impacts the implementation of workplace violence prevention programs. Profit motives result in underfunded WPV programs and a lack of WPV prevention resources. In addition, focus group participants felt that the drive to generate revenue had created a permissive culture among doctors because they 'generate business' (See Table 3). It is important for management to remain aware of the impact of workplace violence on worker retention, productivity, and customer satisfaction, and to understand that the return on investment for an effective workplace violence prevention program is indeed considerable and contributes to an institution's profitability (Gates, Gillespie, & Succop, 2011; Jackson, Clare, & Mannix, 2002).

Although lack of management accountability is an organizational issue, there are many opportunities to assure that all levels of an organization are accountable for their actions and decisions. This may include employee representation on important hospital committees and within-agency, decision-making groups. The workplace violence prevention regulations in New Jersey attempt to assure appropriate employee representation on WPV prevention committees by requiring that 50% of the committee members have direct patient contact (NJDHSS, 2012). Another effective way to demonstrate to employees that management is accountable is by partnering with the unions representing the employees. Focus group participants raised significant concerns that there did not appear to be a strong motivation within hospitals to assure that their program was effective as long as it complied with the New Jersey Violence Prevention in Healthcare Facilities Act regulations. Focus group

participants believed that management's preoccupation with regulatory compliance at times obscured the identification of weaknesses in their workplace violence prevention program.

Today's intense focus of healthcare organizations on 'customer service' also has a significant impact on workplace violence because a customer service focus often results in the mentality that the 'customer is always right.' As highlighted by some of the quotes from our focus group participants (See Table 3), this customer-service mentality can both result in no or little action taken against an abusive patient or family member and intimidation of healthcare providers, to the extent that they are more permissive about unacceptable behavior. Communication of an expectation of acceptable behavior among employees, patients, visitors, and family members can enhance mutual respect for all people while not diminishing the quality of care offered in the healthcare organization.

Focus group participants identified poorly funded social services and current law enforcement approaches to mentally ill patients as having a significant impact on their risk of workplace violence (See Table 3). Often, nurses and allied health staff become default caretakers and managers of patients with broader social problems as a result of poorly funded or ineffective social services. Participants highlighted the need for the hospital to partner and collaborate with social service organizations and law enforcement agencies to manage these high-risk populations. Public policy makers need to recognize the deficiencies that exist in the mental health system and provide resources to effectively address this important public health problem.

Concurrently, we are conducting a study of hospital security directors. Preliminary data demonstrate some similarities and differences in opinions compared to nurses. Presently, the data seem to indicate that hospital security directors are often former law enforcement officers who frequently are very sympathetic to the challenges faced by law enforcement and social services. As a result, they are less likely to suggest the police should change their practices, which is in contrast to the nurses in this focus group who believed that law enforcement and social services should reconsider their practices. Security directors seem to take less issue with the emphasis on customer service in healthcare and accept it as the proper way to operate a healthcare facility, also in contrast to the nurses in this focus group. Other barriers identified by our focus group nurses were similar to those shared by hospital security directors in this concurrent survey.

This study had several limitations, including a lack of randomization among the focus group participants that could have resulted in reporting bias. All focus group participants were members of a worker's union and experienced professionals and therefore their comments may not be representative of nurses and allied health professionals at large. Although the numbers of participants were relatively low, the sampling was appropriate to qualitative methodology and participants were drawn from a variety of hospital professionals, enabling the participant selection process to support the aim of the study. The length of the focus group sessions allowed significant exploration and explanation of ideas expressed.

Summary and Conclusion

This qualitative study utilizing focus groups provided insights regarding the barriers to effective implementation of workplace violence prevention programs. Participants identified seven primary themes representing the major barriers to effective implementation of workplace violence prevention programs in a hospital setting. Many barriers/challenges to effective implementation of WPV programs are both within the program itself and/or related to broader healthcare industry and societal issues. Easy solutions may not be readily apparent. However, creative innovations to support communication, management support, and public policy can address these issues and improve workplace violence prevention programs.

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Table 1

Description and Distribution of Focus Group Session Participants.

Job Description	Number of Participants	Direct Patient Contact
Radiology Technician	2	Yes
Storeroom Clerk	1	No
Emergency Dept. Nurse	3	Yes
Catheter Lab Nurse	3	Yes
Prison Nurse	1	Yes
Clinical Care Nurse	1	Yes
Psychiatric Nurse	4	Yes
Researcher – Mental Health	1	Occasionally
Telemetry	1	Yes
Telemetry – behavioral Health	1	Yes
Post-Anesthesia Care Unit (PACU) nurse	2	Yes
Surgical Intensive Care Unit (SICU) nurse	1	Yes
Critical Care Nurse	1	Yes
Home Health Phlebotomist	1	Yes
Med-Surge Trauma nurse	1	Yes
Certified Nurse’s Aide (CNA)	1	Yes
Information Technology tech	1	No
Case Manager	1	No

Table 2

Themes Identified as Barriers to Effective Implementation of WPV Prevention Programs.

- Lack of action resulting from reporting
- Varying perceptions of what constitutes violence
- Bullying
- Impact of money and profit driven management models
- Lack of management accountability
- Intense focus of healthcare organizations on customer service
- Weak social service and law enforcement approaches to mentally ill patients

Table 3

Specific Quotes from Focus Group Participants Illustrating Specific Themes.

Lack of Action Resulting from Reporting
"you might more likely report something if you knew that there would be an end – something would happen……. it's not only in reporting of it, but it's in what you do with it."
"But we don't know how far that information is transferred or does it go to the state, so forth and so on. Sometimes we think that it's brushed underneath the carpet……"
"….why am I spending my time doing this when there's no consequences?"
"We've had nurses suspended [as a result of incident reports]…what did you do to make this patient that mad?"
Varying Perceptions of What Constitutes Workplace Violence
"I do think it's like that old pornographic definition, I know when I see it, but I can't define it either."
"I think a lot of nurses do that. They make a judgment based on what happened and how they feel about it."
"So, I think when you look at that intent, I think that it does impact how people will report."
"We're looking at the patient or the family member and we're taking that into consideration."
Bullying
"The person that you've reported comes back and it's worse."
"Sometimes I think when you do try to stand up for yourself, then you're labeled as not being a team player."
"I think the new graduate nurses, they get bullied. And it's just kind of like a rite of passage or something."
"Your family is counting on your two per diem shifts. And all of a sudden, because you spoke up, you're not getting shifts."
"…nurses make a comment in another language and then laugh."
Impact of Money and Profit Driven Management Models
"…but they don't allot the resources to institute those [security] policies effectively."
"What they're doing is actually cutting staff ….. and we all know they're going to have problems."
"But as soon as the patient wants to sue the facility, they use that nurse's charges filed with the police as leverage. If we can get that nurse to drop the charges, will you drop your case against us?"
"….The hospital depends on them [doctors] for money. The employee depends on them for money to generate income. So I guess their freedom to abuse is overlooked."
"They [surgeons] bring in the revenue. So, yeah, they're not going to throw money out the window. And that's how they would see it."
"And the threat for the doctors, I'll take my business somewhere else. Somewhere where they'll put up with all my crap."
Lack of management accountability
"don't you [management] want the input of where the violence is happening?"
"And frankly, we've never had this discussion at work about how do we deal with assaults by our dementia patients."
"I've actually had a manager say, you know, nurses need to understand it's part of the job."
Intense focus of healthcare organizations on customer service
"I'm more likely to put up with stuff that other people might consider to be harassment or bullying or whatever, especially from my non-coworkers, from my customers [patients]."
"…they try to make it right with the patient because the patient's always right."
"You've got a complaint against you and you've got bad press and then the hospital's not going to get reimbursed because they're being reimbursed for happy, satisfied patients."

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"My impression is that they're so zeroed in on patient satisfaction, and that concern about safety of the nurses is way down the ladder as far as priority."

Weak Social Services and Law Enforcement Approaches to Mentally Ill Patients

"They're going to bring them to jail, and jail's going to bring them to us. So we're still going to get them."

"That's the recommendation from their local police department. Oh, you can bring him there [to the hospital] so that they can hold him in their ER."

"I mean their answer is, where else are they[homeless and mentally ill]going to go?."

"It's like, okay, I'm homeless, I can spend 10 days [in a facility], that's good. That's better than being on the street."

"That's the problem with the law, too, is what the courts are saying, well, the patient is mentally ill, therefore they should be placed in a hospital, not in a jail."